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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARK LOUIE GO** **128 Hedge Bloom** **Irvine, CA 92618** **Registered Nurse License No. 740461** Respondent.	Case No. 2013-70 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 25, 2008, the Board of Registered Nursing issued Registered Nurse License Number 740461 to Mark Louie Go (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2014, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISION

6. Section 2761(a)(1) of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATIONS

7. California Code of Regulations, title 16, section 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

CAUSE FOR DISCIPLINE

(Incompetence)

9. Respondent is subject to disciplinary action under section 2761(a)(1) of the Code in that Respondent displayed incompetence in carrying out his usual licensed nursing functions as set forth below.

10. Respondent was employed as a registered nurse at the Town and County Manor (TCM) in Santa Ana, California, as a charge nurse on the 11:00 p.m. to 7:00 a.m. night shift, from July 24, 2009 until his termination date on or about December 17, 2010.

12. Between December 4th and 5th of 2010, Respondent and six nurses supervised by Respondent conspired to falsify a narcotic count sheet for two patients in order to hide medication errors made by Respondent, other registered nurses and licensed vocational nurses working at TCM. The circumstances are detailed below.

13. On December 8, 2010, a licensed vocational nurse, Candel, was having a supervisory review with the Assistant Director of Nursing (ADON). During this meeting, Candel, licensed vocational nurse (LVN) gave a narcotic count sheet to the ADON for Patient #1 wherein her

signature had been forged on the document. The ADON immediately began investigating the alleged forgery and interviewing all of the nurses whose names appeared on the narcotic count sheet

Patient #1

14. On December 1, 2010, female Patient #1's physician ordered that she be given two 15 mg tablets of morphine sulfate twice a day at 0600 hours and 1400 hours and an additional one tablet as needed for pain. The nursing staff at TCM administered only one 15 mg tablet to the patient at 0600 and 1400 hours instead of the ordered two tablets. This resulted in the patient being under-dosed on six occasions and with the six tablets that were not given being left on the medication cart. There is no evidence that any employee at TCM diverted the narcotics.

15. On or about December 4, 2010, Eunice, registered nurse (RN), was told by Respondent that there was a drug discrepancy regarding Patient #1's morphine sulfate order. Three nurses, Eunice, RN, Rommel, LVN and Respondent, compared the narcotic count sheet and the physician's orders and discovered that Patient #1 had received only one tablet of morphine instead of the two tablets ordered by her physician on six occasions. It appeared that several nurses were involved in the medication error without naming any specific nurse. Respondent, Eunice, RN, and Rommel, LVN agreed to "fix" the error by making a substitute narcotic count sheet and then "re-doing" the signatures. Eunice RN prepared a new false narcotic count sheet, signed her own name on it and Candel, LVN's signature as well. Eunice, RN admitted signing Rommel, LVN's signature on the false narcotic sheet with his approval.

16. On or about December 5, 2010, Respondent reviewed the false narcotic count sheet prepared by Eunice, RN, and found it still contained errors. Therefore, Respondent showed Christine, LVN, Patient #1's original narcotic count sheet with the morphine sulfate discrepancies and noted that she had made two of the errors. Respondent told Christine, LVN to prepare another replacement narcotic count sheet so that the medication on hand would correctly correspond to the medication listed on the narcotic count sheet. Christine, LVN prepared a new narcotic count sheet and signed her signature and watched Respondent sign his signature in the appropriate slot. Thereafter, Christine, LVN gave the new narcotic count sheet to Jee, LVN. Jee,

LVN reported to Christine, LVN that the morphine sulfate in the bubble pack contained 19 pills and it should have only contained 13 pills if the medication had been administered as ordered by the physician. Christine, LVN and Jee, LVN took the excess medication and wasted it in the Sharp's container without documenting the wastage. After the extra medication was thrown away, the remaining nurses were contacted to re-sign the narcotic count sheet, they all re-signed and the original narcotic count sheet was destroyed.

17. When interviewed, Respondent admitted coming on duty on December 5, 2010, and being presented with a false narcotic count sheet, signing the false document, and failing to follow company policy for medication errors. Respondent admitted making a medication error himself when giving Patient #1 a dose of her morphine sulfate.

Patient #2

19. On November 23, 2010, Patient #2's physician ordered one 2.5 mg Marinol tablet to be given to the patient at bedtime. On November 24, 2010, the physician changed the Marinol order to 5 mg at lunch and 5 mg at dinner. On or about December 2, 2010, Eunice, RN noticed that several nurses had been under dosing Patient #2 by continuing to administer one 2.5 mg. tablet at bedtime and had failed to recognize the physician's change in order. This occurred on approximately 15 occasions. Eunice, RN immediately told her supervisor Rimmy, RN about the errors. Rimmy, RN asked Eunice, RN to prepare a new narcotic count sheet. At 11 pm, when Respondent came on duty, Eunice, RN told him about the medication errors made on Patient #2 and Rimmy, RN's instructions. Respondent asked Eunice, RN to prepare a new narcotic count sheet for Patient #2. Eunice, RN made a false narcotic count sheet, Respondent and five other nurses signed it knowing it was false. The original record was destroyed.

20. On or about December 13, 2010, the six nurses involved in failing to report the medication errors regarding Patient #1 and #2, including Respondent, were suspended from employment at TCM and on or about December 17, 2010, they were all terminated.

21. On December 17, 2010, the Director of Nursing at TCM, wrote a letter to Respondent stating the reasons for his termination from TCM. It indicated that Respondent made at least two dosing narcotic mistakes, he did not handle the medication errors per hospital policy, he

knowingly engaged in a conspiracy to cover up the dosing errors, he falsified documentation in the patient's record and signed his name to it, and he delegated tasks to his subordinates that were not within their scope of practice, such as preparing false narcotic count sheets.

22. TCM Policy regarding medication errors requires a nurse to immediately contact the patient's physician, the DON and nursing supervisor, and complete an incident report. The patient is to be monitored as directed by the physician for any adverse reactions to a medication error. If necessary, the error is to be reported to the consultant pharmacist by the Director. None of these steps were taken by Respondent.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 740461, issued to Mark Louie Go

2. Ordering Mark Louie Go to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: July 25, 2012

for LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant